



NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF CAPITAL DISTRICT DIALYSIS CENTER
CLAIMS FOR DIAGNOSTIC & TREATMENT CENTER SERVICES
PAID FROM
APRIL 1, 2005 – DECEMBER 31, 2008

FINAL AUDIT REPORT
AUDIT #11-2446

James C. Cox
Medicaid Inspector General

APRIL 25, 2014



STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, NY 12204

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

April 25, 2014

[REDACTED]
920 Winter Street
Waltham, Massachusetts 02451-1457

Re: Capital District Dialysis Center
Final Audit Report
Audit #: 11-2446

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of Capital District Dialysis Center" (Provider) paid claims for diagnostic and treatment center services covering the period April 1, 2005, through December 31, 2008.

In the attached final audit report, the OMIG has detailed our scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This final audit report incorporates consideration of any additional documentation and information presented in response to the draft audit report dated August 23, 2013. The mean point estimate overpaid is \$393,812. The lower confidence limit of the amount overpaid is \$215,634. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of \$215,634.

[REDACTED]
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April 25, 2014

If the Provider has any questions or comments concerning this final audit report, please contact [REDACTED] or through email at [REDACTED]. Please refer to report number 11-2446 in all correspondence.

Sincerely,

[REDACTED]

Division of Medicaid Audit, Albany Office
Office of the Medicaid Inspector General

[REDACTED]
Enclosure

cc: [REDACTED]

CERTIFIED MAIL [REDACTED]
RETURN RECEIPT REQUESTED

Ver-4.0

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to assess compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to assess the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

A diagnostic and treatment center is a medical facility with one or more health services which is not part of an inpatient hospital facility or vocational rehabilitation center. It is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition. A diagnostic and treatment center is certified in accordance with Article 28 of the NYS Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis. The specific standards and criteria for diagnostic and treatment center services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the MMIS Provider Manual for Clinics.

PURPOSE AND SCOPE

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for diagnostic and treatment center services complied with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to diagnostic and treatment center services, this audit covered services paid by Medicaid from April 1, 2005, through December 31, 2008.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with \$26,163.15 in Medicaid payments. Of the 100 services in our random sample, 27 services had at least one error and did not comply with state requirements. Of the 27 noncompliant services, some contained more than one deficiency. Specifics are as follows:

<u>Error Description</u>	<u>Number of Errors</u>
Missing Documentation (Dialysis Services)	18
Services Provided by an Unregistered/Unlicensed Practitioner	11
Billed for Incomplete Hemodialysis Services	1

Based on the procedures performed, the OMIG has determined the Provider was overpaid \$6,869.21 in sample overpayments with an extrapolated point estimate of \$393,812. The lower confidence limit of the amount overpaid is \$215,634.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including Diagnostic and Treatment Center claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are conducted to determine if the provider complied with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's Diagnostic and Treatment Center Program

A diagnostic and treatment center is a medical facility with one or more health services which is not part of an inpatient hospital facility or vocational rehabilitation center. It is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition. A diagnostic and treatment center is certified in accordance with Article 28 of the NYS Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis. The specific standards and criteria for diagnostic and treatment center services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter II, as well as the MMIS Provider Manual for Clinics.

PURPOSE, SCOPE, AND METHODOLOGY

Purpose

The purpose of this audit was to determine whether the Provider's claims for Medicaid reimbursement for Diagnostic and Treatment Center complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;

- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to the Provider for diagnostic and treatment center services paid by Medicaid from April 1, 2005, through December 31, 2008. Our audit universe consisted of 5,733 claims totaling \$1,443,343.97.

During our audit, we did not review the overall internal control structure of the Provider. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with the Provider's management personnel to gain an understanding of the diagnostic and treatment center program;
- ran computer programming application of claims in our data warehouse that identified 5,733 paid diagnostic and treatment center claims, totaling \$1,433,343.97;
- selected a random sample of 100 services from the population of 5,733 services; and,
- estimated the overpayment paid in the population of 5,733 services.

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information
- Patient record, including, but not limited to:
 - Admission Information
 - Initial Histories and Assessments
 - Practitioner's Medical Orders;
 - Dialysis Treatment Session Notes;
 - Standing Dialysis Orders
 - Physical Examination Reports
 - Hospital Medical Records
 - Plans of Care
 - Laboratory Test Information
 - Third Party Payments or EOBs; and,
- Any additional documentation deemed by the Provider necessary to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules and Policies of the Medicaid program referenced when conducting this audit:

- Departments of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System and eMedNY Provider Manual.
- Specifically, MMIS Provider Manual Information for All Providers, 10 NYCRR Parts 751 and 757 and 18 NYCRR Part 504.
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."

18 NYCRR Section 504.3

Regulations state: "Fee-for-service providers. (1) All providers . . . must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor . . . must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department . . . for audit and review."

18 NYCRR Section 517.3(b)

Regulations require that bills for medical care, services and supplies contain patient name, case number and date of service; itemization of the volume and specific types of care, services and supplies provided; the unit price and total cost of the care, services and supplies provided; and a dated certification by the provider that the care, services and supplies itemized have been in fact furnished; that the amounts listed are in fact due and owing; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment; and that the provider understands that payment and satisfaction of

this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided.

18 NYCRR Section 540.7(a)(1)-(3) and (8)

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."

18 NYCRR Section 518.1(c)

Regulations state: "Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department."

18 NYCRR Section 540.1

Regulations state: "The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim."

18 NYCRR Section 518.3(a)

Regulations state: "The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished...."

18 NYCRR Section 518.3(b)

Regulations state: "Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record."

18 NYCRR Section 518.3(b)

DETAILED FINDINGS

The OMIG's review of Medicaid claims paid to the Provider from April 1, 2005, through December 31, 2008, identified 27 claims with at least one error, for a total sample overpayment of \$6,869.21 (Attachment C).

Sample Selection

1. Missing Documentation (Dialysis Services)

1, 7, 13, 17, 27, 29, 30, 38, 44, 47,
49, 55, 61, 71, 89, 90, 91, 100

Regulations state, "Chronic renal dialysis services provided in renal dialysis facilities shall comply with the regulations for end-stage renal disease services contained in Title 42 of the Code of Federal Regulations, Public Health, Part 405, Subpart U - Conditions of Coverage of Suppliers of End-Stage Renal Disease (ESRD) Services, (42 CFR Part 405), 1988 edition, published by the Office of the Federal Register, National Archives and Records Service, General Services Administration, as set forth below, which are hereby incorporated by reference, with the same force and effect as if fully set forth at length herein."

10 NYCRR Section 757.1(a)

10 NYCRR Section 757.1(a)(6) incorporates 42 CFR 405.2139 42 CFR 405.2139, 1998 version, provides as follows:

"The ESRD facility maintains complete medical records on all patients (including self-dialysis patients within the self-dialysis unit and home dialysis patients whose care is under the supervision of the facility) in accordance with accepted professional standards and practices. ...

(a) Standard: medical record. Each patient's medical record contains sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately. All medical records contain the following general categories of information: Documented evidence of assessment of the needs of the patient, whether the patient is treated with a reprocessed hemodialyzer, of establishment of an appropriate plan of treatment, and of the care and services provided (see § 405.2137(a) and (b)); evidence that the patient was informed of the results of the assessment described in § 405.2138(a)(5); identification and social data; signed consent forms referral information with authentication of diagnosis; medical and nursing

Sample Selection

history of patient; report(s) of physician examination(s); diagnostic and therapeutic orders; observations, and progress notes; reports of treatments and clinical findings; reports of laboratory and other diagnostic tests and procedures; and discharge summary including final diagnosis and prognosis....

(d) Standard: Completion of medical records and centralization of clinical information. Current medical records and those of discharged patients are completed promptly. All clinical information pertaining to a patient is centralized in the patient's medical record. Provision is made for collecting and including in the medical record medical information generated by self-dialysis patients. Entries concerning the daily dialysis process may either be completed by staff, or be completed by trained self-dialysis patients, trained home dialysis patients or trained assistants and countersigned by staff."

Effective October 14, 2008, 42 CFR 405.2139 was removed and replaced with:

42 CFR 494.170 Condition: Medical records.

"The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.

(a) Standard: Protection of the patient's record. The dialysis facility must--

(1) Safeguard patient records against loss, destruction, or unauthorized use; and

(2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following:

(i) The transfer of the patient to another facility.

(ii) Certain exceptions provided for in the law.

(iii) Provisions allowed under third party payment contracts.

Sample Selection

(iv) Approval by the patient.

(v) Inspection by authorized agents of the Secretary, as required for the administration of the dialysis program.

(3) Obtaining written authorization from the patient or legal representative before releasing information that is not authorized by law.

(b) Standard: Completion of patient records and centralization of clinical information.

(1) Current medical records and those of discharged patients must be completed promptly.

(2) All clinical information pertaining to a patient must be centralized in the patient's record, including whether the patient has executed an advance directive. These records must be maintained in a manner such that each member of the interdisciplinary team has access to current information regarding the patient's condition and prescribed treatment.

(3) The dialysis facility must complete, maintain, and monitor home care patients' records, including the records of patients who receive supplies and equipment from a durable medical equipment supplier.

(c) Standard: Record retention and preservation. In accordance with 45 CFR § 164.530(j)(2), all patient records must be retained for 6 years from the date of the patient's discharge, transfer, or death.

(d) Standard: Transfer of patient record information. When a dialysis patient is transferred, the dialysis facility releasing the patient must send all requested medical record information to the receiving facility within 1 working day of the transfer

Regulations also state;

"The operator shall:

(a) maintain a medical record system;

(b) designate a staff member who has overall supervisory responsibility for the medical record system;

Sample Selection

(c) ensure that the medical record supervisor receives consultation from a qualified medical record practitioner when such supervisor is not a qualified medical record practitioner;

(d) ensure that the medical record for each patient contains and centralizes all pertinent information which identifies the patient, justifies the treatment and documents the results of such treatment;

(e) ensure that the following are included in the patient's record as appropriate:

(1) patient identification information;

(2) consent forms;

(3) medical history;

(4) immunization and drug history with special notation of allergic or adverse reactions to medications;

(5) physical examination reports;

(6) diagnostic procedures/tests reports;

(7) consultative findings;

(8) diagnosis or medical impression;

(9) medical orders;

(10) psychosocial assessment;

(11) documentation of the services provided and referrals made;

(12) anesthesia record;

(13) progress note(s);

(14) follow-up plans; and

(15) discharge summaries, when applicable;

(f) ensure that entries in the medical record are current, legible, signed and dated by the person making the entry;

(g) ensure that medical, social, personal and financial information relating to each patient is kept confidential and made available only to authorized persons;

(h) ensure that when a patient is treated by an outside health-care provider, and that treatment is relevant to the patient's care, a clinical summary or other pertinent documents are obtained to promote continuity of care. If documents cannot be obtained, the reason is noted in the medical record;

(i) maintain medical records at the center in a safe and secure place which can be locked and which is readily accessible to staff; and

(j) retain medical records for at least six years after the last date of service rendered to a patient or, in the case of a minor, for at least six years after the last date of service or three years after he/she reaches majority whichever time period is longer."

10 NYCRR Section 751.7

In 18 instances pertaining to 11 patients, End-Stage Renal Disease (ESRD) services were not documented. For each of the 18 instances, the Patient Short Term Plan of Care which substantiates the physician's review and assessment of the needs of the patient was missing.

2. Services Provided by an Unregistered/Unlicensed Practitioner

1, 2, 5, 6, 22, 23, 27, 36, 58, 88, 96

Regulations state, "If a license, registration or certification is required to render the medical care, services or supplies to be furnished, an applicant must hold a proper and currently valid license, registration and/or certification to be eligible to furnish the care, services or supplies under the medical assistance program."

18 NYCRR Section 504.1(c)

In 11 instances pertaining to 6 patients, the practitioner rendered services prior to receiving his/her license and/or registration from the New York State Education Department.

3. Billed for Incomplete Hemodialysis Sessions

71

Regulations state that by enrolling in the Medicaid program, a provider agrees ... "to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under...[applicable law] when furnished and which were provided to eligible persons."

18 NYCRR Section 504.3(e)

Medicaid policy states, by enrolling in the Medicaid Program, a person agrees to: ... "submit claims for payment for services actually furnished, medically necessary and provided to eligible persons."

*MMIS Provider Manual, Information for All
Providers,
General Policy,
Version 2006-1, Section II;
Version 2004-1, Section II*

In 1 instance, an individual hemodialysis session was billed that was terminated before the treatment was completed.

PROVIDER RIGHTS

In accordance with 18 NYCRR Part 518 which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of \$215,634, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final audit report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #11-2446
Albany, New York 12237

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final audit report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[REDACTED]

If you choose not to settle this audit through repayment of the lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of \$393,812. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at [REDACTED]

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

NAME AND ADDRESS OF AUDITEE

[REDACTED]

920 Winter Street
Waltham, Massachusetts 02451-1457

AMOUNT DUE: \$215,634

PROVIDER ID [REDACTED]

AUDIT #11-2446

**AUDIT
TYPE**

PROVIDER
 RATE
 PART B
 OTHER:

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[REDACTED]
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 2739
File #11-2446
Albany, New York 12237

Thank you for your cooperation.

SAMPLE DESIGN AND METHODOLOGY

Our sample design and methodology are as follows:

- Universe - Medicaid claims for diagnostic and treatment center services paid during the period April 1, 2005, through December 31, 2008.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid Provider claims for diagnostic and treatment center services paid during the period April 1, 2005, through December 31, 2008.
- Sample Unit - The sample unit is a Medicaid claim paid during the period April 1, 2005, through December 31, 2008.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 services.
- Source of Random Numbers – The source of the random numbers was the OMIG statistical software. We used a random number generator for selecting our random sampling items.
- Characteristics to be measured - Adequacy of documentation received supporting the sample claims.
- Treatment of Missing Sample Services - For purposes of appraising items, any sample service for which the Provider could not produce sufficient supporting documentation was treated as an error.
- Estimation Methodology – Estimates are based on the sample data using per unit estimates.

SAMPLE RESULTS AND ESTIMATES

Universe Size	5,733
Sample Size	100
Sample Book Value	\$26,163.15
Sample Overpayments	\$6,869.21
Net Financial Error Rate	26.26%
Mean Dollars in Error	\$68.6921
Standard Deviation	188.8348
Point Estimate of Total Dollars	\$393,812
Confidence Level	90%
Lower Confidence Limit	\$215,634

OFFICE OF THE MEDICAID INSPECTOR GENERAL
CAPITAL DISTRICT DIALYSIS CENTER
REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES
PROJECT NUMBER: 11-2446
REVIEW PERIOD: 4/1/05 - 12/31/08

Sample Number	Date of Service	Rate Code		Amount		Over Payment	DETAILED AUDIT FINDINGS			
		Billed	Derived	Paid	Derived		1. Missing Documentation (Dialysis Services)	2. Services Provided by an Unregistered/Unlicensed Practitioner	3. Billed for Incomplete Hemodialysis Sessions	
1	02/01/07	1641	-	\$ 148.02	\$ -	148.02	X	X		
2	07/24/06	1641	-	148.02	-	148.02		X		
3	07/21/07	1641	-	151.02	151.02	-				
4	11/04/05	1641	-	148.02	148.02	-				
5	06/24/06	1641	-	148.02	-	148.02		X		
6	05/17/06	1643	-	61.72	-	61.72		X		
7	07/01/05	3107	-	765.49	-	765.49	X			
8	10/27/05	1641	-	148.02	148.02	-				
9	01/28/06	1641	-	151.02	151.02	-				
10	03/01/07	3107	-	542.11	542.11	-				
11	11/20/07	1641	-	148.02	148.02	-				
12	05/28/06	1643	-	64.72	64.72	-				
13	01/01/05	3107	-	509.56	-	509.56	X			
14	02/04/06	1641	-	148.02	148.02	-				
15	12/01/07	3107	-	454.79	454.79	-				
16	02/02/06	1643	-	64.72	64.72	-				
17	07/01/08	3107	-	711.61	-	711.61	X			
18	02/07/08	1641	-	148.02	148.02	-				
19	10/19/06	1806	-	50.00	50.00	-				
20	03/05/08	1643	-	61.72	61.72	-				
21	06/25/06	1643	-	61.72	61.72	-				
22	08/31/06	1806	-	50.00	-	50.00		X		
23	01/21/06	1643	-	64.72	-	64.72		X		
24	09/22/06	1643	-	61.72	61.72	-				
25	06/24/08	1643	-	61.72	61.72	-				

OFFICE OF THE MEDICAID INSPECTOR GENERAL
CAPITAL DISTRICT DIALYSIS CENTER
REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES
PROJECT NUMBER: 11-2446
REVIEW PERIOD: 4/1/05 - 12/31/08

Sample Number	Date of Service	Billed	Rate Code		Paid	Amount		Over Payment	DETAILED AUDIT FINDINGS				
			Derived	Derived		Derived	Derived		1. Missing Documentation (Dialysis Services)	2. Services Provided by an Unregistered /Unlicensed Practitioner	3. Billed for Incomplete Hemodialysis Sessions		
26	10/01/06	3107	-	-	\$ 665.88	\$ 665.88	\$ -	-	-	X	X	X	
27	12/26/06	1806	-	-	130.00	130.00	-	130.00	-				X
28	08/01/05	3107	-	-	1,154.77	1,154.77	-	-	-	X			
29	11/01/07	3107	-	-	541.11	-	-	541.11	-	X			
30	08/01/06	3107	-	-	542.69	-	-	542.69	-	X			
31	08/10/07	1643	-	-	61.72	61.72	-	-	-				
32	06/17/07	1643	-	-	61.72	61.72	-	-	-				
33	05/24/07	1643	-	-	61.72	61.72	-	-	-				
34	06/05/07	1641	-	-	148.02	148.02	-	-	-				
35	03/01/06	3107	-	-	539.36	539.36	-	-	-				
36	07/29/06	1643	-	-	61.72	-	-	61.72	-			X	
37	06/11/05	1806	-	-	150.00	150.00	-	-	-				
38	11/16/06	1806	-	-	130.00	-	-	130.00	-	X			
39	09/01/07	3107	-	-	583.05	583.05	-	-	-				
40	12/09/06	1641	-	-	148.02	148.02	-	-	-				
41	08/07/07	1641	-	-	151.02	151.02	-	-	-				
42	06/01/07	3107	-	-	808.36	808.36	-	-	-				
43	07/03/07	1641	-	-	151.02	151.02	-	-	-				
44	10/24/06	1806	-	-	100.00	-	-	100.00	-	X			
45	11/27/07	1641	-	-	148.02	148.02	-	-	-				
46	08/01/07	3107	-	-	1,053.25	1,053.25	-	-	-				
47	07/01/05	3107	-	-	1,280.02	-	-	1,280.02	-	X			
48	07/18/08	1643	-	-	61.72	-	-	61.72	-				
49	07/26/07	1641	-	-	148.02	-	-	148.02	-			X	
50	10/01/06	3107	-	-	475.75	475.75	-	-	-				

OFFICE OF THE MEDICAID INSPECTOR GENERAL
CAPITAL DISTRICT DIALYSIS CENTER
REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES
PROJECT NUMBER: 11-2446
REVIEW PERIOD: 4/1/05 - 12/31/08

Sample Number	Date of Service	Rate Code		Amount		Over Payment	DETAILED AUDIT FINDINGS		
		Billed	Derived	Paid	Derived		1. Missing Documentation (Dialysis Services)	2. Services Provided by an Unregistered /Unlicensed Practitioner	3. Billed for Incomplete Hemodialysis Sessions
51	11/03/07	1641	-	\$ 148.02	\$ 148.02	\$ -			
52	09/18/06	1643	-	61.72	61.72	-			
53	08/29/06	1806	-	100.00	100.00	-			
54	02/01/07	3107	-	474.06	474.06	-			
55	02/27/07	1641	-	148.02	-	148.02	X		
56	05/01/08	3107	-	828.34	828.34	-			
57	12/31/05	1641	-	148.02	148.02	-			
58	09/10/05	1806	-	150.00	-	150.00		X	
59	08/30/05	1806	-	100.00	100.00	-			
60	01/22/07	1641	-	148.02	148.02	-			
61	12/11/07	1641	-	151.02	-	151.02	X		
62	11/28/06	1806	-	50.00	50.00	-			
63	06/29/07	1643	-	61.72	61.72	-			
64	03/20/08	1641	-	151.02	151.02	-			
65	10/15/06	1643	-	61.72	61.72	-			
66	11/15/05	1641	-	148.02	148.02	-			
67	05/21/08	1641	-	148.02	148.02	-			
68	11/15/05	1806	-	100.00	100.00	-			
69	08/14/06	1643	-	61.72	61.72	-			
70	05/12/05	1806	-	100.00	100.00	-			
71	02/15/07	1641	-	148.02	-	148.02	X		
72	12/01/05	3107	-	401.17	401.17	-			X
73	10/30/07	1641	-	148.02	148.02	-			
74	06/01/06	3107	-	541.67	541.67	-			
75	12/01/06	3107	-	739.11	739.11	-			

OFFICE OF THE MEDICAID INSPECTOR GENERAL
CAPITAL DISTRICT DIALYSIS CENTER
REVIEW OF DIAGNOSTIC AND TREATMENT CENTER SERVICES
PROJECT NUMBER: 11-2446
REVIEW PERIOD: 4/1/05 - 12/31/08

Sample Number	Date of Service	Billed	Rate Code		Amount		Over Payment	DETAILED AUDIT FINDINGS				
			Derived	Derived	Paid	Derived		1. Missing Documentation (Dialysis Services)	2. Services Provided by an Unregistered /Unlicensed Practitioner	3. Billed for Incomplete Hemodialysis Sessions		
76	11/01/06	3107	-	-	\$ 580.16	\$ 580.16	\$ -					
77	12/12/06	1806	-	-	120.00	120.00	-					
78	07/23/08	1643	-	-	61.72	61.72	-					
79	02/26/08	1641	-	-	148.02	148.02	-					
80	01/01/06	3107	-	-	287.49	287.49	-					
81	08/01/06	3107	-	-	372.17	372.17	-					
82	01/01/05	3107	-	-	655.83	655.83	-					
83	11/08/06	1806	-	-	20.00	20.00	-					
84	01/10/08	1641	-	-	148.02	148.02	-					
85	10/03/05	1806	-	-	200.00	200.00	-					
86	02/21/08	1641	-	-	148.02	148.02	-					
87	11/23/07	1641	-	-	148.02	148.02	-					
88	09/12/06	1643	-	-	51.72	-	51.72		X			
89	01/05/06	1806	-	-	80.00	-	80.00		X			
90	01/22/06	1643	-	-	64.72	-	64.72		X			
91	02/01/06	1643	-	-	64.72	-	64.72		X			
92	06/26/07	1641	-	-	148.02	148.02	-					
93	10/08/06	1643	-	-	61.72	61.72	-					
94	11/01/05	3107	-	-	425.16	425.16	-					
95	05/01/05	3107	-	-	681.76	681.76	-					
96	07/29/06	1806	-	-	50.00	-	50.00		X			
97	03/18/08	1641	-	-	151.02	151.02	-					
98	08/01/07	3107	-	-	839.20	839.20	-					
99	02/01/05	3107	-	-	488.48	488.48	-					
100	09/01/06	3107	-	-	410.27	-	410.27		X			
Totals							\$ 26,163.15	\$ 19,293.94	\$ 6,869.21	18	11	1

FINAL DISPOSITION FOR SAMPLED SELECTIONS CHANGED FROM DRAFT TO FINAL AUDIT REPORT

CAPITAL DISTRICT DIALYSIS CENTER
 DIAGNOSTIC AND TREATMENT CENTER SERVICES AUDIT
 AUDIT #11-2446
 AUDIT PERIOD: 4/1/05 - 12/31/08

BRIDGE SCHEDULE

SAMPLE #	FINDING	DRAFT REPORT		CHANGE	FINAL REPORT	
		AMOUNT	DISALLOWED		AMOUNT	DISALLOWED
12	Missing Documentation (Dialysis Services)	\$64.72		<u>(\$64.72)</u>		\$0.00
15	Missing Documentation (Dialysis Services)	\$454.79		<u>(\$454.79)</u>		\$0.00
16	Missing Documentation (Dialysis Services)	\$64.72		<u>(\$64.72)</u>		\$0.00
25	Missing Documentation (Dialysis Services)	\$61.72		<u>(\$61.72)</u>		\$0.00
48	Missing Documentation (Dialysis Services)	\$61.72		<u>(\$61.72)</u>		\$0.00
52	Missing Documentation (Dialysis Services)	\$61.72		<u>(\$61.72)</u>		\$0.00
78	Missing Documentation (Dialysis Services)	\$61.72		<u>(\$61.72)</u>		\$0.00
93	Missing Documentation (Dialysis Services)	\$61.72		<u>(\$61.72)</u>		\$0.00
94	Missing Documentation (Dialysis Services)	\$425.16		<u>(\$425.16)</u>		\$0.00
84	Billed for Incomplete Hemodialysis Sessions	\$148.02		<u>(\$148.02)</u>		\$0.00
82	Service Delivery Document Not Signed by a Licensed Health Professional - (Dialysis Services)	\$655.83		<u>(\$655.83)</u>		\$0.00
92	Service Delivery Document Not Signed by a Licensed Health Professional - (Dialysis Services)	\$148.02		<u>(\$148.02)</u>		\$0.00
TOTALS		<u>\$2,269.86</u>		<u>(\$2,269.86)</u>		<u>\$0.00</u>

Note: The adjustments shown above only reflect those that were revised as a result of the provider's response. All other adjustments remain the same as shown in the Draft Audit Report.